

**CASE MANAGEMENT IN  
Long-Term Care Integration: An Overview of  
Current Programs and Evaluations**

**Written for the:**

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## EXECUTIVE SUMMARY

This report synthesizes existing knowledge regarding case management, including its principal characteristics, models, and effectiveness. In so doing, this report provides the background information and frameworks California's counties can use to design effective case management programs within integrated and coordinated long-term care systems.

This report was completed in conjunction with the California Center for Long-Term Care Integration. The California Center for Long Term Care Integration is a collaborative effort of UCLA, USC, and the California Department of Health Services to provide assistance to the state and counties in their efforts to locally integrate funding and access to health care and supportive services for their aged, blind and disabled citizens, in accordance with the provisions of AB-1040 (1995).

In this report, we describe various definitions and models of case management, provide a framework for counties to use as they design case management programs, and discuss the various aspects of assuring quality and evaluating effectiveness of case management programs. A companion report by Terri Taylor of the California Department of Health Services Office of Long-Term Care, *Case Management in Long-Term Care Integration Programs: An overview of the CM programs in Arizona, California, Minnesota, Texas, & Wisconsin*, provides a more in-depth description of specific case management programs currently operating in various states. Together, these documents can assist counties to design effective case management programs that promote seamless integration of long-term care.

This report is organized into four sections. The first section describes the characteristics of case management. The second section consists of descriptions of

common and emerging models of case management. Third, the evaluation of case management's quality and effectiveness is discussed. Finally, current evaluations, unresolved issues, and challenges for the future are raised.

### *Characteristics of Case Management Programs*

The Case Management Society of America defines case management as: "A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and service to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes" (in Malone & Osborne, 2000, p.240). However, case management characteristics differ tremendously across programs, including what case management is, why it is provided, where it is provided, and how it is provided.

The goals of case management can be client-oriented, administrative, or system-oriented (Applebaum & Austin, 1990). Client-oriented goals focus on assuring that clients are receiving appropriate services that support informal care, improve access to formal care, and promote individual and family well-being. Administrative goals concern increasing horizontal and vertical efficiency in order to improve service utilization and constrain costs. System-oriented goals address the entire service delivery system, in terms of efficient, high-quality, targeted non-institutional services that also contain costs.

All successful case management programs employ three general processes: assessing/planning, implementing/delivering, and reassessing/adjusting (Aliotta, Archibald, Brown, Chen, Fox, 2000). These processes are reflected in the following key components of case management: targeting and outreach; comprehensive assessment; care planning, coordination/implementation/ linkage; client advocacy, monitoring, follow-up/reassessment;

and, discharge/termination. In implementing these components, case managers in long-term care service delivery settings typically play the roles of broker/arranger, service coordinator, advocate, counselor, and/or gatekeeper.

### *Case Management Models*

The most common case management models in long-term care include the brokerage model, the managed care model, and the integrated care model. These three traditional models of case management share a common concern with helping vulnerable clients to access services, but differ dramatically with regard to fundamental components such as the extent of care manager fiscal responsibility, the level of care manager authority, and the intensity of care management activities.

We recommend that the term “care coordination,” rather than “care management,” be used to describe the broad continuum of professional and paraprofessional activities that can be involved in assisting disabled individuals to access services. In accordance with a suggestion by Challis (1999), we recommend that the term “case management” be reserved for the intensive set of professional activities associated with ongoing, in-person contact required by vulnerable individuals with complex or changing conditions. Within the broad range of activities included in care coordination, the appropriate level and type of activity will vary depending upon client needs and system characteristics, with only the most vulnerable clients receiving intensive case management. Clients possessing greater internal and external resources may only require assistance in identifying and accessing services, and may not desire more intensive case management.

Perhaps the most fully-articulated system of protocols for matching care coordination services to client needs is the Differentiated Care Management model developed in Devon,

England (Searle, 1999). The differentiated model includes three distinct levels of assessment and care coordination based on specific levels of assistance required by consumers. Examples of similar United States initiatives which utilize protocols for targeting more intensive case management services to those most at risk include the Robert Wood Johnson Cash and Counseling Initiative, the Wisconsin Family Care Program, the Texas STAR+PLUS program, and the Ohio PASSPORT program.

### *Evaluation and Quality*

Quality in long-term care case management can be evaluated in terms of three domains: 1) Structure, 2) Process, and 3) Outcomes. Structure refers to the organizational context within which case management services are provided, including such factors as agency certification, staff-client ratios, types of case management services provided, resources available, and case manager capability. However, there is surprisingly little evidence to support the assumption that structural standards alone can ensure quality case management practice.

The process domain of evaluation compares how case management services are provided to some set of external standards. Process standards for quality case management have been developed in areas such as the following: consumer rights, preferences, and values; comprehensive assessment; care plan; implementation; monitoring; reassessment; discharge and termination; quality improvement; and efficient use of resources (Geron & Chassler, 1994). Existing case management programs vary with regard to how closely they adhere to established standards of quality case management practice.

The ultimate test of quality in case management is whether a program results in its intended outcomes. Among the outcome domains that typically have been considered in evaluating case management are the following:

- Cost, including Cost Effectiveness and Cost Containment
- Service Utilization, including Acute Care Hospitalization, Nursing Home Utilization, and Home and Community-Based Services
- Functional Capacity, including Physical, Mental, and Social Functioning
- Family Functioning, including the Amount and Type of Informal Care, as well as Types and Levels of Caregiver Strain
- Quality of Life, including Autonomy, Psychological Well-Being, and Satisfaction

A review of the limited existing evidence regarding the effectiveness of case management reveals relatively consistent patterns of results concerning these outcome domains. Overall cost often increases. There is often a decrease in acute care and institutionalization, accompanied by an increase in use of home and community-based services. No clear pattern can be identified with regard to outcomes related to functional capacity. Case management often impacts family functioning and quality of life, including decreases in caregiver strain, increases in social/psychological well being and service satisfaction, and decreases in unmet need.

Several case management program characteristics appear to be associated with successful outcomes. Small caseloads, specific targeting criteria, case manager training, case manager authority (i.e., financial control and/or flexibility), and matching case management intensity to client need all seem to contribute to successful outcomes.

### *Current Evaluations and Emerging Issues*

A number of evaluations of case management programs currently underway hold promise for enhancing substantially existing knowledge regarding the effectiveness of case management models. Especially notable among these current projects are the following: Cash and Counseling, Minnesota Senior Health Options, Oregon's Senior and Disabled Services programs, Texas STAR+PLUS, and the Wisconsin Family Care Program.

Quality assurance and evaluation are essential components of any case management program and must be incorporated into each program's design and ongoing operation. General principles for designing evaluation and quality assurance systems include the following:

- Define outcomes and identify how outcomes are directly related to interventions
- Link planning, administrative, and evaluation practices together
- Assign primary responsibility for evaluation, but also involve a broad range of staff participation

The increased consumerism of the coming years will naturally impact the nature of case management, how it is provided and paid for, and how quality is defined. Increased attention to consumer education will be essential, in order to assure that individuals understand the benefits of case management and make the best choices possible from available service options. At present, it is not at all certain how much extra the public is willing to pay for quality case management, or to what extent consumers are willing to pay for case management at all! Existing evidence does suggest, however, that case management remains an essential and generally effective component of any comprehensive effort to develop an integrated and coordinated long-term care system.

## INTRODUCTION

Case management plays a key role in efforts to integrate long-term care services into a seamless continuum of care. In this paper, we review the key components of case management practice that need to be considered in planning and implementing integrated community-based long-term care services. We examine the various definitions, functions, and settings that describe case management; the common roles and tasks of case managers; the principles, values, and goals of case management in long-term care; and, the major case management models. We also discuss some of the current problems and challenges related to the changing phenomenon of case management. This paper accompanies the work of Terri Taylor of the California Department of Health Services Office of Long-Term Care. Taylor's work, entitled, *Case Management in Long-Term Care Integration Programs: An overview of the CM programs in Arizona, California, Minnesota, Texas, & Wisconsin*, provides an in-depth comparison of specific case management programs currently operating in various states.

This paper is organized into four sections. The first section describes the characteristics of case management, including: *what case management is, why case management is provided, where it is provided, and how it is provided*. The second section consists of descriptions of common and emerging models of case management. Third, the evaluation of case management's effectiveness and usefulness is discussed with a focus on quality. Finally, unresolved issues and challenges for the future are raised.

Case management has been a part of human service practice since the end of the nineteenth century, when Mary Richmond, one of the early pioneers of the field of social work, stressed coordination and consumer direction in social case work (National Association of Social Workers, 1992). In the 1920s and 1930s, an early form of case management was used in psychiatric care and by public health nurses (Huber, 2000).

Case management emerged as a distinct concept in the 1960s to address the “complex, fragmented, duplicative and uncoordinated” systems that existed as a result of funding programs through strict categorical channels (Rubin, 1992). The term case management began to appear in the literature in the early 1970s (Grau, 1984) and referred mostly to the mental health field, as a response to the discharge of thousands of mental patients from state hospitals. Mental health service integration projects in the 1970s featured case managers, called “system agents” at that time, who coordinated services for clients and assisted them through the service system (Rubin, 1992).

According to Quinn (1993), case management in long-term care began as a method for helping individuals to access programs and overcome bureaucracy through the Allied Services Act of 1972. Two forces contributed to the increased utilization of case management services in long-term care: the independent living movement of the 1970s; and, increased numbers of disabled elders with complex chronic care needs and no family to care for them. However, it was not until the 1980s that case management was covered as a benefit through Medicaid waivers. With increased recognition of age-based and functional impairment-based eligibility for services, long-term care case management is now being called upon to address the needs of older individuals as well as the needs of younger disabled adults. Today, the practice of case management in

long-term care is offered in a variety of forms across multiple settings and with a diverse array of goals and objectives.

## **CHARACTERISTICS OF CASE MANAGEMENT**

Case management models vary tremendously. Indeed, as Austin and McClelland (1996) have stated, “If you have seen one case management program, you have seen one case management program.” Definitions of case management can be organized into a myriad of frameworks. In this section, we will lay out the basics of *what, why, where, how, and by whom*. In other words, what are some of the general definitions of case management; what are its values and goals (why); in what settings do case managers work and with which client populations (where); what tasks or functions are performed by case managers (how); and finally, who provides case management and what are the qualifications of case managers (by whom)?

### ***Definitions of Case Management (“What?”)***

Case management definitions differ according to the source or type of the definition. For example, regulators may provide administrative definitions that describe the goals of case management, but do not provide detailed means for meeting these goals. Professional groups may provide definitions that consist of more functional descriptions, which include the steps or tasks involved in meeting the purpose that case management serves. Finally, experts in the field of case management can provide definitions based on actual research and experience in the field. These expert definitions may combine the purpose of case management with its various functions,

usually encompassing a broad view of the purpose and tasks involved in case management.

AB-1040 defines case management as follows:

*“Care or case management, including assessment, development of a service plan in conjunction with the consumer and other appropriate parties, authorization and arrangement for purchase of services or linkages with other appropriate entities, service coordination activities, and follow-up to determine whether the services received were appropriate and consistent with the service plan.” § 14139.33(a)*

This definition focuses on the major tasks to be performed through the process of case management, emphasizing that case management has both consumer-directed and administrative components.

The central role of the case manager in the service delivery system is emphasized in the Consolidated Omnibus Reconciliation Act (COBRA), which describes case management as “a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization” (Davidson, et al., 1991). Similarly, Applebaum and Austin (1990) define case management as “an intervention using a human service professional to arrange and monitor an optimum package of long-term care services.”

Case management has a unique role in assuring that vulnerable individuals receive the services they need. The National Chronic Care Consortium (2000), for example, describes the primary focus of case management as “coordinating services for vulnerable clients” (p.1). Great Britain’s Social Services Inspectorate defines care management as “the process of tailoring services to individual needs” (Challis 1999). However, case management also has an administrative function, which has become

more prominent in recent years, including purchasing or allocating services, restraining costs, and monitoring quality (Kane and Thomas, 1993). Indeed, an analysis of twelve HCFA demonstrations offering community-oriented long-term care programs described case management primarily as an administrative activity that directs client movement through the long-term care system (Capitman, Haskins, and Bernstein, 1986).

A comprehensive definition of case management, underscoring its procedures as well as its individual and system-level objectives, is provided by the Case Management Society of America: “A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and service to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes” (in Malone & Osborne, 2000, p.240).

Lauber (1992) defines case management in community mental health facilities as “an integrated or coordinated system of: (1) individualized primary personal services (consisting of assessment, planning, treatment, and monitoring functions); and (2) environmental (or secondary) personal services (consisting of advocacy, support, linkage and networking), with support from (3) interface services (consisting of client identification and outreach, administrative activities, public relations, and education and training)” (p. 9). According to this definition, services are designed to facilitate client competence and are dictated by the client’s functioning level, case manager’s skills and knowledge, and agency’s policies.

### ***Principles and Values of Case Management***

A number of basic principles and values have been identified as integral to high quality case management systems in long-term care. These include the following:

- A consumer-centered service that respects consumers' rights, values, and preferences
- Coordinates all and any type of assistance to meet identified consumer needs
- Requires clinical skills and competencies
- Promotes the quality of services provided
- Strives to use resources efficiently (Geron and Chassler, 1995)
- Comprehensive model
- Addresses unique medical and social needs of the geriatric patient
- Involves consumers in care planning and decision making
- Provides appropriate access to specialty care when needed
- Recognizes the critical role of respite care services for informal care providers
- Prevents further disability by focusing proactively on ambulatory care
- Coordinates case management through an interdisciplinary team of professionals (including those with geriatric expertise), paraprofessionals, and family members or other caregivers
- Includes a full range of community-based services in the benefits package (Fillit and Leonard [in Taylor, 2001])

### ***Goals of Case Management (“Why?”)***

The goals of case management can be client-oriented, administrative, or system-oriented (Applebaum & Austin, 1990). Client-oriented goals focus on assuring that clients are receiving appropriate services that support informal care, improve access to formal care, and promote individual and family well-being. Administrative goals concern increasing horizontal and vertical efficiency in order to improve service utilization and constrain costs. System-oriented goals address the entire service delivery system, in terms of efficient, high-quality, targeted non-institutional services that also contain costs.

#### *Client-oriented goals*

Regulatory definitions often focus on access to services as a primary client-oriented goal of case management. For example, the Social Security Act (section 1905(a)(19) and 1915(g)(2)) defines Medicaid case management as:

*“services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services.”* (HCFA, 2001)<sup>1</sup>

The California Partnership for Long-Term Care regulations also define case management in terms of access to services:

*“Care Management/Care Coordination takes an all-inclusive look at a person’s total needs and resources, and links the person to a full range of appropriate services using all available resources”* (CPLTC 1999 regulation §58005).

Similarly, San Francisco’s Case Management Plan for Senior Services and Community-Based Long-Term Care defines case management as “a formal strategy which coordinates and facilitates access to a variety of services in a timely manner for people who need assistance in organizing and managing their care.”

The definition of case management presented in *The Encyclopedia of Aging* focuses more directly on the care clients receive:

*“...a service function directed at coordinating existing resources to assure appropriate and continuous care for individuals on a case-by-case basis...”* (White, 1987)

Marie Weil (1985) also focuses on the care clients receive, indicating that the purpose of case management is to “assure that a client receives needed services in a supportive, effective, efficient, and cost-effective manner.”

The National Council on the Aging (NCOA, 1994) suggests a broader and more ambitious set of client-level goals for case management programs:

- maintaining the greatest amount of independence and dignity for the individual
- enabling the person to remain in the most appropriate environment
- building and strengthening family and community support
- Improving availability and quality of services

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<sup>1</sup> Health Care Financing Administration website, last updated January 19, 2001.  
<http://www.hcfa.gov/medicaid/smd119c1.htm>

The client-oriented goals of case management also relate to goals of the entire long-term care system:

- Improving or maintaining health
- Improving or slowing the deterioration of functional abilities
- Meeting needs for care and assistance
- Enhancing psychological well-being
- Enhancing social well-being
- Maximizing client independence and autonomy
- Permitting clients to live in the least restrictive settings feasible
- Promoting a meaningful life
- Promoting quality of life (including dignity, privacy, social relationships, and social participation) (Kane, Kane & Ladd, 1998, p. 18)

Similarly, the British Social Services Inspectorate (1999) has proposed the following national objectives for adult care in the United Kingdom:

- Promote Independence
- Live safe, full, normal lives, in own home (to the extent possible)
- Avoid unnecessary hospitalization
- Maximize carers' capacity to work
- Enable informal carers to provide care for as long as they and the service user wish

### *Administrative Goals*

Administrative-level goals concern the cost, provision, and utilization of services. The focus may be financial, such as lowering the cost of a service; it may concern service provision, such as decreasing the use of more expensive services; or it may be related to service outputs, such as increasing or decreasing the number of clients served. Kane, Kane & Ladd (1998) describe these types of goals as utilization management. A goal of fewer hospital days or lower use of institutional long-term care services may be considered administrative-level goals. These goals generally are easier to quantify than are client-oriented or system-oriented goals. In the United States, administrative goals tend to take priority in case management policies and

program design, as compared with other countries, such as the United Kingdom, where goals and objectives appear to be more explicitly client-focused (Social Services Inspectorate, 1999).

Case management can help to constrain long-term care costs by

- assuring use of appropriate community-based services
- providing an appropriate, comprehensive and coordinated response to the person's need(s) that addresses prevention as well as rehabilitation and maintenance
- serving as an integral link to increase access to community-based services
- reaching a specified target population (NCOA, 1994).

The increase in managed care service delivery, for example, has led to increased use of case management as a cost saving measure designed to trim hospital stays or avoid them altogether (NCCC, 1997) for frail patients within the community. However, as noted by Fireman (2000), decreased cost can only be achieved by one or more of the following:

- decreased service use
- using less expensive services to meet the same need
- reducing the cost of existing services (increasing efficiency)
- reducing client needs
- diverting costs (i.e. from acute to skilled nursing, or from skilled nursing to home care)

Administrative goals of case management also include facilitating the development of services that promote quality and efficiency in the use of resources (Geron et al., 1995). Rubin (1987) defines case management as, "an approach to service delivery that attempts to ensure that clients with complex multiple problems and disabilities receive all the services they need in a timely and appropriate fashion" (p. 212).

### *System-oriented Goals*

System-oriented goals are broader than administrative-level goals and focus more on the entire community-based long-term care service-delivery system. Examples of service delivery-level goals include: the provision of a seamless continuum of care, improving access to services, and improving timeliness of services. The National Council On Aging (NCOA, 1994) definition of care management, for example, offers the following system-oriented goals:

*“Care management is a component of the community care system. Its purpose is to make the system work more efficiently in order to assure that individuals receive assistance that is responsive to their needs.” (p. 3).*

A national objective for adult services in the United Kingdom is “an adequate supply of appropriate, cost-effective, and safe adult social services” (Social Services Inspectorate, 1999). Other policy recommendations developed in the United Kingdom to address the need to decrease institutional care and promote community social care included the following system-oriented goals (Challis, 1993):

- To promote the development of home care, adult day care, and respite...to enable people to live in their own homes
- To ensure that service providers make practical support for caregivers a high priority
- To make proper assessment of need and good case management the cornerstone of high-quality care
- To promote the development of a flourishing independent sector alongside good-quality public services
- To clarify the responsibilities of agencies and so to make it easier to hold them accountable for their performance
- To secure better value for taxpayers' money by introducing a new funding structure for social care

### *Possible Goal Discrepancies*

Case management goals differ from the perspectives of funders, providers, and clients (White, 2000). Like the administrative-level goals discussed above, case management goals from a funder's perspective will mostly be related to cost and efficiency of services. Case management providers are more likely to value consumer satisfaction, consumer education and empowerment, the ability to maintain clients' functioning at optimal levels with minimal intervention, and high rates of goal attainment among consumers. From a client's perspective, the most valued goals will be those that directly influence a client's quality of life. These goals include the ability to remain active or function independently, to have control over one's own life, or to receive affordable help without barriers (White, 2000).

Conflicts between goals may exist when there are insufficient resources to meet the stated goals. Conflicts may also occur when the case manager and client or family member do not agree on a problem, need, goal, or the appropriateness of a service (NCOA, 1994). It is important to note that such goal conflicts are virtually inevitable. For example, efforts to decrease institutionalization will almost inevitably conflict with the goal of lowering costs for home and community-based services. Policies for setting priorities among potentially competing goals and an established process for achieving cooperation in resolving goal discrepancies are essential steps for optimizing goal attainment at all levels.

## ***Client Settings and Populations (“Where?” & “To Whom?”)***

### *Where is Case Management Provided?*

Case management is offered in a wide variety of settings, including those providing medical care, catastrophic care, and long-term care (Cline, in NCCC, 1997). The American Hospital Association (in NCCC, 2000) describes the following contexts for case management: primary care settings such as physicians’ offices; medical settings, such as an acute, post-acute, or skilled nursing settings; social settings such as home and community-based service agencies; medical-social settings such as home health agencies; and finally, vocational settings.

### *To Whom Is Case Management Provided?*

In addition to the field of long-term care, case management may be provided to the following populations: persons with physical or developmental disabilities; children; individuals experiencing mental illness, alcohol or drug addiction, homelessness, or HIV/AIDS; currently or recently incarcerated persons; the unemployed; or many others. Within these populations, it is usually the most vulnerable groups that are most likely to benefit from case management, including those at highest risk of institutionalization, with lowest levels of social support, or with multiple, chronic problems.

## ***Roles and Tasks of Case Managers (“How?”)***

Despite the diverse definitions of case management, there is surprising consensus on the tasks performed by case managers, and the roles that case managers play, even across client populations and settings.

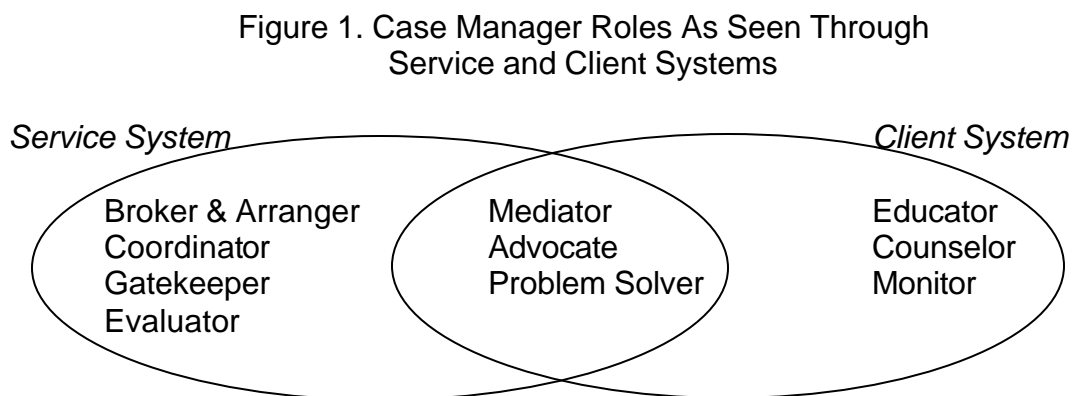
## *Roles of Case Managers*

Applebaum & Austin (1990) and Kodner (2001) identify ten potential roles for case managers:

- Broker and Arranger
- Coordinator
- Gatekeeper
- Evaluator
- Educator
- Counselor
- Monitor
- Mediator
- Advocate
- Problem Solver

The most common roles of a case manager in long-term care service delivery settings include that of broker/arranger, service coordinator, advocate, counselor, and gatekeeper.

Figure 1 illustrates how these roles may focus primarily on either the service system, the client system, or both:



Service system roles involve optimizing the system's ability to respond effectively to client needs. As a broker or service coordinator, the case manager is responsible for

identifying and arranging services. In these roles, the case manager's primary focus is on assuring that clients receive the services they need from other direct care providers; the case manager's contact with the client system may be quite limited. In the brokerage model of case management, to be presented in a later section of this paper, the case manager is likely to play this role most of the time.

As gatekeeper, the case manager is concerned with containing costs and assuring appropriate utilization of resources, including ensuring that services are provided only to those clients who are appropriate for receiving them. Gatekeeping is a key feature of the managed care model of case management. In the role of evaluator, the case manager is responsible for assuring that case management goals are met, whether client-oriented, administrative, or system-oriented. This typically involves assessment of process and outcome objectives as well as mechanisms for quality assurance and quality improvement.

Client system roles involve helping clients to optimize their ability to make effective use of existing services in order to meet their needs and improve their well-being. As a counselor, for example, the case manager assists clients and their families with identifying and resolving personal and interpersonal barriers to obtaining care and meeting individual and family needs. As educator, the case manager may teach clients and family members skills needed to provide care, to arrange needed services, or to judge the quality of services, thus empowering them to assume as much responsibility as possible for their own care. The case manager may also work with the client system to monitor the care that is being received, whether from informal or formal sources.

The case manager also may operate at the interface of formal and informal support systems. As problem solver, the case manager may respond to particular barriers to service access or utilization. As mediator, the case manager may work to facilitate problem resolution between the service and client systems. As advocate, the case manager may intervene with the service delivery system to assure that clients receive appropriate, high quality services. The advocacy role is common to all major models of case management, although the case manager's level of authority as the client's advocate may vary among the models. For instance, when the case manager and service providers are independent providers, the case manager may have less authority than in a managed care model in which the case management services are offered through the same organizational auspice as the service providers.

### *Tasks or Functions of Case Managers*

All successful care coordination programs generally employ three general processes: assessing/planning, implementing/delivering, and reassessing/adjusting (Aliotta, Archibald, Brown, Chen, Fox, 2000). These processes are reflected in the following key components of case management (Applebaum et al., 1990; Geron et al., 1995; Morse, 2000; NCOA, 1994; Vourlekis et al., 1991; Weil, 1985):

- targeting and outreach
- comprehensive assessment
- care planning
- coordination/implementation/ linkage
- client advocacy, monitoring, follow-up/reassessment
- discharge/termination

The following section describes standard practices in each of these key components of case management, reflecting standards that have been developed by leaders in the field of long-term care case management (NCOA, 1994).

#### Targeting and outreach.

Targeting involves identifying client groups for whom case management has the greatest likelihood of being effective, while outreach involves marketing services specifically to those clients who are most apt to benefit and educating them about service availability. Populations usually targeted include those that are most vulnerable or “at risk” of institutionalization, those with multiple impairments that are expected to last over a long period of time, those who use multiple services and expect to use them over a long period of time, or those without informal social supports. Targeting and risk identification have been described as major predictors of effective and efficient outcomes of case management programs (Challis, 1999; National Chronic Care Consortium, 2000).

#### Comprehensive assessment

The assessment is the first, and perhaps most important step in planning services for an individual (Scharlach et al., 2000). At a minimum, the assessment determines an individual’s eligibility for services and need for case management (Holt, 2000). The assessment process also provides an evaluation of a person’s present situation and needs, including current and potential strengths and limitations, and the adequacy of formal and informal services currently being received (Davidson, Penrod, Kane, Moscovice & Rich, 1991). Ideally, the assessment employs a comprehensive, multidimensional, functionally oriented approach. The California Partnership for Long-

Term Care states that the assessment take an “all inclusive look at a person’s total needs and resources” (CPTLC regulation §58005d, 1999).

The assessment typically is conducted by a trained professional, and according to the National Association of Social Workers (1992), this person should “be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible” in carrying out all case management functions. Regulations under the Health Insurance Portability and Accessibility Act require that, to ensure quality, certification to determine benefit eligibility under long-term care insurance be performed by a licensed health care provider (Scharlach, 2000), such as a physician, professional nurse, or licensed social worker. It is important that assessments be performed by trained professionals who have received training in performing accurate assessments (Scharlach et al. 2000).

Lebow and Kane (1991) present assessment in case management as akin to an anthropologist’s exploration of people, but with the eye and ear of a social work clinician. They describe assessment as having four overlapping phases: (1) assessing the fit between the client and the service, (2) assessing the family or significant others, (3) assessing the client and his or her environment, and (4) assessing the situation over the course of the service.

The assessment process varies according to the requirements of the program; it may be as brief as a few eligibility questions or may involve an in-depth, multi-dimensional profile of a client’s situation to determine his or her needs and resources (Quinn, 1993). A comprehensive, or “all-inclusive,” assessment includes an evaluation of a person’s needs by describing all relevant areas of the individual’s life. According to

the Nuffield Community Care Studies Unit (NCCSU) in the United Kingdom, the comprehensive assessment should be a systematic, standardized way of assessing the consumer's functional and cognitive capacity and limitations, strengths, abilities, and resources. This includes descriptions of the person's use of medications, cognitive status, emotional/psychological status, ability for self-care, nutrition status, role of informal supports, environmental/safety risks, emergency response ability, tobacco or alcohol use, social activities, rehabilitation potential, and the level of case management necessary.

#### Care planning

The assessment is translated into service provision through the development of a care plan. It is essential that all problems identified in the assessment process be addressed in the care plan. This can be facilitated through development of a problem list that includes all problems identified through the assessment (Schneider, 1989).

The care plan documents the strategy that the case manager and the client will undertake to resolve the problems identified by the assessment. The care plan should include a written list of problem-oriented goal statements and should include specific ways in which goals will be met, including services from paid and unpaid sources, and should reflect the consumer's values and preferences and should be sensitive to the client's cultural beliefs (Geron et al., 1995). The services proposed on the care plan should support and enhance, not replace, those services already being provided informally (NCOA, 1994). Care plan development can be most effective when care plans meet standards such as an inclusion of problem statements, goal statements, and service descriptors (Scharlach et al., 2000). The NCCSU (1998) summarizes that care

plans should “be sensitive to [his or her] ethnicity, religion, culture, and any special needs” (p. 45) and that the role of the case manager should be described on the care plan.

Goal statements are used in the care plan to specify desired client-oriented outcomes. According to St. Coeur (1996), goal statements provide direction to the case management process. She describes the most common features of well-written goals in a mnemonic known as “SMART” or, “Specific, Measurable, Achievable, Realistic, and Timely.” Of these five characteristics of goal statements, measurability is most important in helping the client and the case manager to determine whether the client has attained his or her desired outcome.

Each service recommended in the care plan should be described in detail. First, they enable clients to make informed decisions about the case manager’s recommendations. Second, they provide clients and their informal support networks with detailed information about how to implement the care plan.

Service descriptors that should be reflected in the care plan include the type of service needed, the person or agency who can provide the service, the cost and payment source of the service, the frequency of the service, and the roles of the various parties involved in monitoring the service (Scharlach et al., 2000). Including all service descriptors in the care plan provides the client and the case manager with clear information describing how the services will be implemented. This can be especially helpful when clients are responsible for implementing and monitoring their own care.

### Implementation

Care plan implementation includes activities designed to assist the client in obtaining the services specified in the care plan. The case manager may provide information about services, educate clients and family members about accessing services, or may actively arranging for or coordinate specific services. NCCSU (1998) summarize that care plans should be implemented in a way that coordinates formal and informal services so that they are timely and cost-effective.

The intensity of implementation services provided by the case manager may differ according to the type of case management model offered. Brokerage models provide more referral services as part of implementation while the case manager performs fewer coordination activities. Other models may give the case manager fiscal authority to purchase services on behalf of the client (Davidson, et al., 1991), thus involving the case manager in more intense implementation services such as arranging for services. Integrated models that use a multidisciplinary team approach provide the case manager with an environment where service providers typically assist in the implementation of services.

### Monitoring

Care monitoring can evaluate the quality of services that the client receives and determine whether intended goals are being met. Monitoring may also fulfill agency or governmental requirements to verify that clients still qualify for case management services (Scharlach, 2000). Through monitoring, the case manager monitors both the progress of the client and the adequacy of services.

Monitoring is also necessary to determine the effectiveness of the case management process itself. Case managers must be accountable for their decisions

and the services they are providing to the clients they serve. They must provide sufficiently detailed documentation in order to provide the agency with an understanding of the clients' needs. Finally, the monitoring function of case management should allow for the evaluation of the effectiveness of the case manager and the case management program. Rothman and Sager (1998) view this evaluation of agency efficacy as a "macroscopic byproduct" of the case management monitoring function.

Monitoring requires regular contact with clients, family members, and service providers, either by telephone or in-person. Case management standards generally agree that monitoring contacts with clients should include the following: a review of consumer goals, needs, and desired outcomes; an assessment of consumer satisfaction with the care plan and with services provided; and an evaluation of effectiveness of the type and frequency of monitoring being provided (Scharlach et al., 2000). This provides the case manager with the opportunity to identify problems that the client or family may be experiencing (Quinn, 1993). Rothman and Sager (1998), for example, have developed practice guidelines for monitoring using formal and informal means at three different levels (the client level, the formal service system, and the informal network).

Intensity of monitoring should vary according to the needs of the consumer (Geron, et al., 1995). More intensive monitoring is required when client needs fluctuate or are deteriorating, when the client relies heavily on family caregivers, or when there is a conflict between clients and caregivers (NCCSU, 1998). However, the frequency of contact often varies according to the type of case management model under which the case manager functions (Davidson et al., 1991). The brokerage model, as it is less

hands-on and leads to larger caseloads, may involve less monitoring than a model that provides more intense case management, or a model that may have a higher level of financial risk associated with the care provided, as a managed care model would have.

### Reassessment

Reassessment “completes the loop” of case management (Quinn, 1993). The reassessment process includes a re-evaluation of the goals and care plan developed at the baseline assessment. As client needs and circumstances change over time, regular reassessment of the client maintains an updated profile of the client (Quinn, 1993). If the reassessment shows changes in the client’s situation, the care plan should be modified to reflect changes in client needs (Robinson, 1997). Reassessments determine the need and preferences for continued services and monitoring.

### Discharge and Termination

Discharge and termination, sometimes called disengagement (Holt, 2000), are appropriate when clients no longer require case management services (Geron et al., 1995). Services may no longer be appropriate if a client’s situation has improved, usually as a result of improved physical functioning or the addition of outside resources (Holt, 2000). Services may also no longer be appropriate if the client’s situation has worsened and it is determined that services be provided under a different program.

Upon termination of case management services, a written plan should be developed with the client in order to plan for continued care needs. A written discharge plan for meeting current and future needs is a useful tool for clients and family members to use when case management services are no longer provided. The discharge plan is essential for documenting client participation in the termination process and is a tangible

instrument that provides written assistance for clients and caregivers as they begin to manage their own care.

### ***Who Provides Case Management?***

Case management services in the field of long-term care may be provided by professional or paraprofessional workers trained in the fields of nursing, social work, or mental health. Generally, the background of the case manager is determined by the type of setting in which the case management services are provided (Cline, in NCCC, 1997).

Nursing case management often focuses on facilitating appropriate use of health care benefits (Wisser, 2001). Case managers who are nurses usually influence the patient's movement through the health care continuum, and the case management services are usually provided within a health care setting.

Social work case managers typically employ a social model of care. The National Association of Social Workers (1992, p. 22) presents four processes that are emphasized by case managers who are trained from a social work perspective:

1. Enhancing the developmental, problem-solving, and coping capacities of people
2. Promoting the effective and humane operation of systems that provide resources and services to people
3. Linking people with systems that provide them with resources, services, and opportunities
4. Contributing to the development and improvement of social policies.

While increased case manager preparation and training generally is associated with better care outcomes at reduced costs (NCCSU, 1998), there also is evidence that extensive staff training is not always cost-effective. Recent research by the Personal Social Services Research Unit (PSSRU, 2000) found that less complex cases can be

handled most efficiently by staff who have general, but not intensive, case management preparation. Targeting highly specialized case managers to more complex cases promotes better use of staff time and results in more efficient use of resources.

### **PROGRAM DESIGN CRITERIA**

In designing a case management program, it is important to consider dimensions such as the following:

- Goals/expected outcomes of case management services
- Organizational auspice
- Target population
- Financing/reimbursement mechanisms
- Level of financial risk
- Case manager authority
- Case management activities
- Case manager qualifications
- Caseload size
- Intensity of case management services

The goals of a case management program impact all other aspects of program design and implementation. As discussed previously, goals may range from simply promoting service access to improving quality of life, from constraining service costs to optimizing the entire long-term care service delivery system. Clarity about goals and consensus among relevant constituencies can increase the likelihood that a case management program will achieve its intended outcomes.

The organizational auspice of the program refers to the structural setting in which the program resides. The program may be an independent case management agency, or it may exist within a larger structure such as an adult day health setting, a home-health setting, a hospital, or a social service agency. Although the organizational auspice in which a case management program exists directly influences the way in

which case management is performed as well as the role of the case manager, there is no evidence suggesting that one organizational setting for case management is inherently better than another.

Targeting criteria, sometimes referred to as risk identification or risk screening, may include variables such as age, level of functional impairment, Medicare/Medicaid eligibility, cognitive functioning, or social support system. Setting realistic, quantifiable targets has been a key activity of successful case management programs (Applebaum & Austin, 1990). Well-defined targeting criteria can identify individuals who are most likely to benefit from case management (Kodner 1993). Moreover, targeting has been shown to increase the effectiveness of case management (Challis, 1999; Bernabei 1998; Austin & McClelland, 1996).

Financing and reimbursement mechanisms include the source of funding, amount of funding, and the form of the funding. Examples of specific financing mechanisms used include waivers, fee for service, pooled funding, client cost sharing, and capitated/prospective funding. However, funding for case management programs generally is fragmented and weak, with little public financial support other than Medicaid waivers. Depending upon its auspices, a case management program may or may not bear any financial risk for the services received by its clients.

The scope of a case manager's authority is another important issue in program design. The ability to purchase services on behalf of the client or to approve the payment of services can determine the kinds of services the case manager is able to secure for the client. Case management activities and functions also vary, from only

assessment and care planning, to care plan implementation and monitoring, and/or counseling and other clinical tasks.

Case management programs also vary with regard to the level of professionalization required of their case managers. Case managers may be paraprofessionals, or professionally trained in a specific discipline such as nursing or social work. In the Long-Term Care Demonstration Projects, paraprofessionals were usually responsible for screening clients as well as arranging and monitoring services. There is mixed evidence that case managers who have higher education levels provide more effective services than paraprofessionals when presenting needs are not complex.

Caseload size and intensity of the case manager/client relationship both potentially impact the effectiveness and efficiency of a case management program. Caseload size is affected by case mix, as well as the extent to which there is a need for service coordination or monitoring. Some clients may need more assistance with implementing services, but less help monitoring once services are in place. Evidence from the National Long-Term Care Channelling Demonstration Project suggests that having sufficiently small caseloads is a prime factor in the ability of a case management program to produce positive outcomes (Davies & Chesterman, 1995).

## **MODELS**

### ***Traditional Models of Case Management within Long-Term Care***

Case management in long-term care has traditionally consisted of three broadly defined models: the brokerage model, the managed care model, and the integrated care

model. The following section compares these three models on the program design criteria described above (see Table 1).

### *Brokerage Models*

Brokerage models, also referred to as the generalist approach to case management (Huber, 2000), were among the earliest models of case management, developed as an attempt to guide clients through dysfunctional delivery systems (Austin, 1993). Brokerage models are seen within a range of organizational auspices; they can be freestanding agencies such as private geriatric care management programs, or can consist of a special unit within a larger organization. They usually are offered as part of a home and community based service delivery system, and tend to adopt a social rather than medical approach.

In a brokerage model, the case management entity usually acts as a free-standing agent responsible for “linking” the client with other organizations, agencies, or networks of services, with no formal administrative or financial relationship with service providers in the delivery system. Because they have no control over reimbursement for direct services, case managers in brokerage models have relatively little authority in making sure services are delivered to their clients. Without any organizational relationship to service providers, the case management entity faces no financial risk for service utilization or client outcomes, although there may be limited financial risk associated with the provision of case management services, especially if reimbursement is capitated.

Case managers in a brokerage model typically perform assessments, develop care plans, and provide referrals to specific services, with minimal coordination or

monitoring of services. Less intensive case management may consist of barely more than information and referral, while some brokerage models include more intensive services such as counseling with the client or advocating for the client to eliminate service barriers. Case management programs under a brokerage model tend to have relatively high caseloads, making the brokerage model most appropriate for clients with simple needs who are at low risk for institutionalization. Qualifications of case managers in brokerage models may vary, although case managers often are paraprofessionals or professionally trained generalist social workers.

Examples of brokerage model case management programs include private geriatric care managers, MSSP, and Linkages programs. Case management under long-term care insurance may be considered a brokerage model if the care management provider agency is paid on a fee-for-service basis and has no organizational or financial relationship with insurance companies or service providers.

### *Managed Care Models*

Managed care models assist clients in obtaining the most appropriate services, which may involve facilitating or restricting access to certain services. Often referred to as gatekeepers, or utilization review case managers, case managers in the managed care model are usually responsible for managing client benefits and agency costs within a larger service delivery system, often a health maintenance organization or other health care provider. Clients targeted in the managed care model are apt to be more functionally impaired than clients served by the brokerage model, and are more likely to have acute medical needs. These clients are usually at risk of hospitalization or other high cost medical services. For this reason, case managers in the managed care model

have been described as “guards against institutionalization” (Beatrice, 1979, in Morrow-Howell, 1992). The managed care model typically involves capitated, prospective financing, which places the agency at financial risk for services utilized by clients.

Case management services under managed care models typically consist of service coordination and time-limited care monitoring in addition to assessment and care plan development. Case managers in managed care models tend to have a high level of authority in assuring that clients receive services offered through their organization. As part of a larger service provider system, the case manager has the ability to coordinate services in a more streamlined approach than if the case manager were linking the client to separate service providers. Services provided under managed care models are most often health care services, but case managers can refer clients to outside service providers for social services. Case managers within the managed care model typically are professionally-trained nurses or social workers and tend to have smaller caseloads than their counterparts under the brokerage model.

### *Integrated Models*

Integrated case management, according to the National Chronic Care Consortium (1995), involves integration of care management within an entire system of long-term care. Integrated systems offer client support and continuity across service settings and strive to eliminate duplication and fragmentation of services. Integrated case management models exist within an interdisciplinary organizational structure that strives to provide all necessary services for clients. Services provided include direct medical as well as social services, including counseling, advocacy, and ongoing coordination and monitoring of care services.

Like managed care models, integrated service models are capitated, often through waiver programs, creating a high level of financial risk due to the program's obligation to meet all client needs. Since the integrated program relies on participation from various disciplines, the case manager has less authority than in a managed care model, but more authority than in a brokerage model. Use of a multi-disciplinary team limits the case manager's authority to approve or deny services, and spreads some of the financial risk across disciplines rather than placing it solely on the case manager, as is the case in managed care models.

In the integrated model the case manager typically takes on the entire range of case management tasks, including counseling and other clinical tasks in addition to conducting the assessment and developing the care plan. The case manager and service providers share the same organizational auspice, potentially leading to improved communication as the case manager is likely to be informed of and involved in all areas of service provision.

Case managers within integrated models are most often professional social workers or nurses trained in working with interdisciplinary groups, as the case manager is responsible for coordinating the multidisciplinary effort and acting as the primary liaison to the client. The integrated model typically targets clients who are at high risk of institutionalization, and caseload sizes tend to be relatively small. An example of an integrated case management model is the PACE program.

**Table 1. Key Variables for Comparing Case Management Models**

<b>Key Variables</b>	<b>Brokerage Model</b>	<b>Managed Care Model</b>	<b>Integrated Model</b>
<b>Main Goals</b>	Case management in this model serves a “linking” purpose, connecting the client with a network of separate providers. The primary goal is to ensure that the client receives the most appropriate services in a reasonable amount of time, avoiding duplication of services and barriers to services.	Also called gatekeeper models, the purpose of this model is to promote the use of cost-effective, community alternatives to more expensive health services. The primary goal is to facilitate or restrict access to services to control utilization and thereby, control costs, while also assisting the client to obtain the most appropriate services	The integrated model provides case management services through an already established network of providers. The primary goal is ongoing prevention of the progression of disability using an interdisciplinary approach
<b>Organizational Auspice</b>	The model is usually offered in a community-based setting, which can range from an independent private case management practice to a publicly funded case management program.	This model is offered through a managed care organization, which can work with clients across settings.	The model is offered through a network within a community setting. Services often include some type of adult day health care integration.
<b>Target Population</b>	The target population is broadly defined, including those with functional impairment.	The target population typically includes individuals with functional impairments as well as medical needs, who are at risk of needing more costly services if initial needs are not addressed.	The target population consists of people who already face a potentially significant disability and are at high risk of the disability progressing, leading to institutionalization or other high cost care.
<b>Financing and Reimbursement Mechanisms</b>	Funding for brokerage services is usually not capitated and may be offered through public or private resources.	Funding may consist of a capitated rate, most often through public or private insurance.	Funding for integrated services is capitated, often through waiver programs.
<b>Level of Financial Risk</b>	The CM provider agency does not pay for services, therefore does not face financial risk.	The CM provider or funding source pays for services covered under the managed care agreement and therefore faces some financial risk as CM reimbursement is capitated.	The integrated case management network pays for all services and therefore faces high financial risk as reimbursement is capitated.

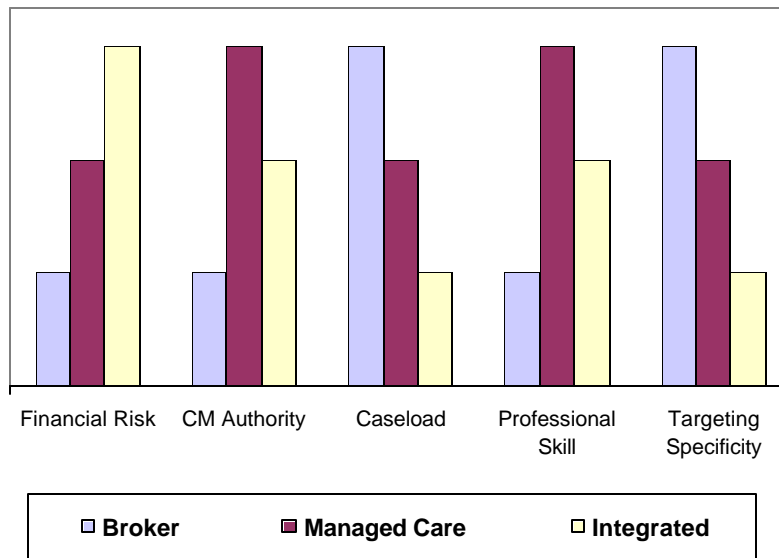
**Table 1. (Cont'd.) Key Variables for Comparing Case Management Models**

<b>Key Variables</b>	<b>Brokerage Model</b>	<b>Managed Care Model</b>	<b>Integrated Model</b>
<b>Case Manager Authority</b>	The CM does not have authority under this model to approve payment of any services.	The CM holds a high level of authority in approving or restricting service utilization.	CM authority under this model is usually balanced through the use of interdisciplinary care teams, thus giving the CM limited authority.
<b>Case Manager Activities</b>	CM performs assessment and care plan only, with some brokering of services if necessary.	Assessment, care plan development and implementation are performed, plus ongoing monitoring usually on a time-limited basis.	All components of case management, including counseling or other clinical social tasks.
<b>Case Manager Qualifications</b>	The CM in this model is usually an MSW or a paraprofessional social service provider.	The CM is usually a trained health professional, most likely an RN or MSW.	The CM is most likely a professionally trained RN or MSW.
<b>Caseload Size</b>	Most often caseloads are high. Funds are often dependent on units of service or other measurements of volume.	Caseloads are often higher than integrated models, but lower than most brokerage models.	Caseloads are most likely lowest for integrated models, as the case manager is responsible for coordinating a multidisciplinary effort.
<b>Intensity of CM Services</b>	Services usually offered on a short-term basis until a presenting problem is resolved. In this model, the CM typically spends less time directly with the client than in other models.	Services usually offered on a short-term basis until a presenting problem is resolved. During the short-term, services may be intense, but often they are not continued at a high level of intensity.	Services most often are long-term throughout a condition's evolution and may follow a client across care settings. Integrated services are likely to be most intense as they involve the largest amount of staff time compared with other models.

### ***Variations in the Three Models***

Figure 2 compares the brokerage, managed care, and integrated models with regard to their relative levels of financial risk, care manager authority to purchase services, caseload size, level of professionalization, and targeting specificity.

**Figure 2. Common Variables for Comparing Care Management Programs**



### ***Care Coordination and Differentiated Case Management***

#### ***Care Coordination***

The three traditional models of case management described above share a common concern with helping vulnerable clients to access services, but differ dramatically with regard to fundamental components such as the extent of care manager fiscal responsibility, the level of care manager authority, and the intensity of care management activities. Indeed, the diversity of activities and responsibilities often

subsumed under the term “case management” makes it difficult to assure common understanding of the meaning and scope of case management itself.

In accordance with a suggestion by Challis (1999), we recommend that the term “case management” be reserved for the intensive set of professional activities associated with ongoing, in-person contact required by vulnerable individuals with complex or changing conditions. We recommend that the term “care coordination” be used to describe the broad continuum of professional and paraprofessional activities that can be involved in assisting disabled individuals to access services, through linkages between the client system and the service system.

Care coordination includes the variety of services designed to assist disabled persons to identify and access needed services, including education, information and referral, facilitation of services, as well as ongoing care coordination and monitoring (Chen et al., 2000). Within the broad range of activities included in care coordination, the appropriate level and type of activity will vary depending upon client needs and system characteristics. Vulnerable clients with especially complex situations will require the most intense level of activity, “case management,” providing intensive and extensive support services to meet their basic care needs. Clients possessing greater internal and external resources may only require assistance in identifying and accessing services, and may not desire more intensive case management.

Matching the appropriate level of care coordination with client needs can have advantages for clients as well as case management systems. Research on community social services conducted by Britain’s Personal Social Services Research Unit has shown that intensive case management is more cost-effective with service users who

are more physically and cognitively disabled, while less intensive care coordination can be more cost-effective with those who are less physically and cognitively disabled, or who have short-term needs, such as people being discharged from acute care hospitals.

### *Differentiated Case Management*

There have been a number of recent efforts to develop protocols to enable systematic matching of appropriate levels of care coordination with client needs and system capabilities. These efforts are predicated upon a commitment to maximizing client-directed care, as well as a recognition that intensive case management is not cost-effective for all clients, and may in some cases be counterproductive.

Perhaps the most fully-articulated system of protocols for matching care coordination services to client needs is the Differentiated Care Management model developed in Devon, England (Searle, 1999). Development of this model followed recognition by the Devon Local Authority (equivalent to a county department of social services) that it simply did not have sufficient resources to provide case management to all disabled adults who fell under its jurisdiction, as required under national law. The Local Authority also recognized that clients' and caregivers' needs vary, as do the complexity of their situations and their ability or desire to manage their own care, making it likely that many service users did not require full-blown case management.

The differentiated model developed in Devon includes three distinct levels of assessment activity and three distinct levels of care coordination. The three levels of assessment are termed simple, moderate, and complex. A simple assessment typically consists of a telephone assessment of an individual whose situation is stable, whose

needs are clearly-defined, and who simply needs information about programs and services. A moderate assessment typically consists of a written self-assessment questionnaire, perhaps accompanied by telephone or face-to-face contact with a paraprofessional. A moderate assessment is appropriate when the situation appears to be stable and predictable, and there is agreement about the primary needs for which assistance is required. A complex assessment involves a face-to-face visit by a professional social worker or nurse. It may also involve assessments by specialists from multiple agencies and multiple disciplines. A complex assessment is appropriate when needs are complex, poorly-defined and subject to fluctuation; when risks are not well known or difficult to manage; or when a permanent change of home environment is being considered.

The first level of care coordination service, known as self-care management, consists primarily of information and advice offered through a Help Desk Service, where paraprofessional workers provide “a point of contact for universal services.” Self-care management is appropriate for individuals and families who are able to implement services independently and do not need further assistance besides information about available service options.

The second level, care coordination, consists of basic assistance in obtaining services, for individuals who need help implementing their care plans or negotiating with service providers. Care coordination is provided by paraprofessionals as part of the Help Desk function. Client needs may be simple or complex, within the context of a planned and predictable situation where risks are known and can easily be managed.

Personal care management, the highest level of care coordination offered under the differentiated model, provides more intensive services through a designated case manager who is a professional social worker or nurse. These services, which represent only 20% of cases in Devon, are reserved for those clients who are identified as being most vulnerable, or who request high levels of case manager involvement. Clients receiving personal care management are the only group in which a case manager is assigned to their specific case on an ongoing basis, and these may be the only services in the program that can truly be considered “case management” (Searle, 1999). The main features of the differentiated model include emphasis on consumer directed-care; the use of a centralized information and referral system; multiple types of assessment; and, multiple levels of care coordination.

Examples of similar United States initiatives which utilize protocols for targeting more intensive case management services to those most at risk include the Robert Wood Johnson Cash and Counseling Initiative, the Wisconsin Family Care Program, the Texas STAR+PLUS program, and the Ohio PASSPORT program. Ohio’s PASSPORT program, for example, uses a triage system in which program applicants are assigned to a service category depending on their level of disability and amount of informal support. Clients enter a single entry point and receive services according to a differentiated model. The first level consists of a number to call for needed service information. The second level, for those with moderate needs, consists of ongoing case management primarily through telephone contact. Clients with more severe needs receive case management services in-person. Evaluations of PASSPORT and other

differentiated case management models will be discussed further in the evaluation section of this paper.

### ***Summary***

In the last twenty-five years, case management has emerged as a central component of efforts to improve community-based long-term care systems. Indeed, without case management, the service delivery system would be a confusing maze impossible for most clients to navigate. Yet, as we have seen, case management itself remains poorly defined, marked by great diversity in its conceptualization and implementation. Confusion with regard to the scope and goals of case management have limited the ability of service providers, policy-makers, and planners to design effective and efficient case management systems that will meet consumer needs and optimize service systems in a manner consistent with fiscal realities.

We have proposed that the concept of care coordination be adopted to encompass the broad range of activities currently labeled case management, with the term “case management” reserved for those more intensive activities, typically involving higher levels of case manager responsibility and authority, which are apt to be needed by individuals with the most complex and vulnerable situations. Further, we have proposed a set of program design criteria upon which individual care coordination or case management programs can be assessed. These criteria are part of a framework that includes: program definition (what?), program goals (why?), client settings (where?), populations (to whom?), and activities or tasks (how?).

The following section of this paper will examine the quality and effectiveness (how well?) of case management programs and also consider how best to evaluate

case management programs for quality procedures and outcomes. The paper will describe evaluations of innovative demonstration programs and discuss implications for ensuring quality in ongoing programs.

## **EVALUATION: ASSESSING, ASSURING, AND ENHANCING QUALITY**

### ***Quality In Long-Term Care Case Management***

Quality in long-term care case management can be evaluated in terms of three domains: 1) Structure, 2) Process, and 3) Outcomes. Although these domains will be discussed individually, they do co-exist essentially as pieces of a larger puzzle, influencing and impacting each other tremendously. It is important to note that any comprehensive examination of quality will take into consideration all three aspects.

#### ***Structure***

Structure refers to the organizational context within which case management services are provided. Yee (1990) refers to structure as “the capacity of a service system or organization to provide care, including the resources to assure an adequate capacity” (p. 30). Organizational capacity typically is indicated by agency certification, adequate staff-client ratios, and administrative review practices. Structure also pertains to the types of case management services provided, the resources needed to provide services, the level of case manager authority, case manager credentials, education, supervision, training, and the capability of case managers for performing case management functions. There is an underlying assumption that adequacy of such structures is a prerequisite for quality service.

Structural characteristics traditionally have been the dominant mechanism for assuring quality. Indeed, state and federal requirements typically address structural features such as job descriptions, reporting, or records. Moreover, Kane and Degenholtz's survey of 95 exemplary case management agencies found that 73% had explicit structural standards for quality case management, whereas only 9% had explicit process standards, and only 2% had quality standards related to client outcomes (Kane and Degenholtz, 1997).

For the most part, structural characteristics are easy to assess and fit with our intuitive notion that greater capacity will result in better care. However, Kane and others have questioned whether devoting more resources to long-term care case management will necessarily result in better care. Despite the widespread assumption that having more professionalized staff and smaller caseloads will result in better quality, to date there has been limited empirical evidence to support this position. National Channeling Demonstration sites that had smaller caseloads, for example, did produce better client outcomes. However, one recent study of case management in the Medicare Alzheimer's Disease Demonstration found no systematic effect of caseload size on case management activity (Newcomer, Arnsberger, & Zhang, 1997). Moreover, England's Personal Social Services Research Unit has shown that less professionalized staff can be more cost-effective with less complex cases. It is not surprising then, that many case management agencies have begun to experiment with strategies designed to reduce staff-client ratios and utilize greater numbers of paraprofessionals, such as conducting routine assessments and care planning by telephone or by proxy. The impact these methods have on quality is not yet known.

Evaluation of structural quality involves examining the presence or lack of structures, the adequacy of these structures, and their implications for quality case management. However, as Phillips, Applebaum, and Atchley (1990) succinctly state, “structural standards alone cannot ensure the quality of case management practice” (p. 59). Characteristics of the case management process must also be considered.

### *Process*

A process approach examines how case management services are provided, typically by comparing what is done to some set of external standards. Process entails measuring the use of resources, or the method in which services are actually provided. It includes aspects of case management controlled by the case management agency and individual case manager.

Some process characteristics of good quality practice seem obvious, as inherent in the aesthetics of case management itself. Kane, Kane, and Ladd (1998) have suggested, for example, that there are certain basic “enabling” characteristics of good practice, which represent the minimum necessary for quality case management. We expect that care managers will be honest and decent in their interactions with clients and their families, that they will be reliable, and that they will have at least some minimal level of interpersonal and technical competence. We might also assume that quality case management includes at least some minimal level of client involvement and consumer direction, as well as mechanisms for feedback among clients, family members, and service providers.

### Process Standards

Several attempts have been made to establish standards and guidelines for the practice of case management. For example, the National Council on Aging and the National Association of Social Workers both have developed a set of practice standards for case managers. Such standards can then be operationalized in terms of observable indicators by which to evaluate the case management process.

Perhaps the most comprehensive effort to develop guidelines for quality case management practice was Connecticut Community Care's Robert Wood Johnson-funded effort, drawing upon the extensive wisdom of an advisory committee composed of established national leaders in the field of long-term care case management (Geron & Chassler, 1994). This initiative resulted in specific guidelines for quality practice in nine areas, including: consumer rights, preferences, and values; comprehensive assessment; care plan; implementation; monitoring; reassessment; discharge and termination; quality improvement; and efficient use of resources. Table 2 identifies summary guidelines for each area.

**Table 2: Connecticut Community Care Summary Guidelines**

(Geron & Chassler, 1994, pp. ix-xi)

<b>AREA OF CASE MANAGEMENT</b>	<b>SUMMARY GUIDELINE</b>
<i>Consumer Rights, Preferences and Values</i>	Case management should be undertaken at the request of and with the informed consent of the consumer or the consumer's proxy decision maker if the consumer is legally unable to make decisions. Within the context of payer requirements, case managers should endeavor to determine and strive to honor the values and preferences of the consumer in all phases of case management practice.
<i>Comprehensive Assessment</i>	Case management requires a comprehensive, systematic and standardized assessment of the consumer's functional and cognitive capacity and limitations, and other needs, strengths, abilities and resources. Case managers should draw on their experience, expertise, observations and judgment to analyze and synthesize the information obtained in the assessment in order to determine the consumer's needs for services, supports and resources.

<i>Care Plan</i>	Case management requires a care plan for each consumer. The care plan should be based on the findings from the consumer's comprehensive assessment, reflect the consumer's values and preferences, include a written list of problem-oriented goals, describe the services from paid sources and unpaid help provided by family and friends that will be used to achieve the goals, provide a timetable for the activities and services included, indicate the role and responsibilities of the case manager, include estimates of the cost of the care plan, and identify who will pay for services.
<i>Implementation</i>	Case management requires the timely and cost-effective implementation of each consumer's care plan through the arrangement and coordination of provider services and unpaid assistance from family and friends. In the course of implementation, the case manager assumes many roles and performs a variety of tasks, including advocacy and referral.
<i>Monitoring</i>	Case management requires monitoring sufficient to determine that case management is being provided at an appropriate level of intensity to meet the consumer's needs, that provider services are implemented in accordance with the care plan and are of high quality, and that problems are resolved promptly. The intensity of monitoring varies with the needs and preferences of the consumer. Monitoring serves as an opportunity to review the consumer's status and situation, assess the consumer's satisfaction with case management and provider services, evaluate the efficacy of provider services in addressing identified consumer needs and review the costs of the care plan.
<i>Reassessment</i>	Case management requires a comprehensive, systematic and standardized reassessment of the consumer. Reassessments are scheduled based on clinical judgment of the likelihood of changes in consumer functional or cognitive capacity or personal situation or are performed when warranted by changed in the consumer's situation. Reassessments determine the consumer's continued need and preferences for services, including case management, and the appropriate frequency and method of monitoring required.
<i>Discharge and Termination</i>	Case management should be terminated when the consumer no longer needs case management. However, case management should permit consumers who do not currently need or prefer case management services but who require paid long-term care services, to continue to receive those services when allowable under payer requirements. Consumers will need to be informed that in some programs payer requirements specify that receipt of case management monitoring and oversight is a condition of receiving provider services.
<i>Quality of Case Management and Provider Services</i>	Case management requires a commitment to providing the highest quality case management services and to ensuring that provider services are also of the highest quality. A quality improvement system is thus an essential component of case management services.

<i>Efficient Use of Resources</i>	Case management requires a commitment to the efficient use of public and private resources to meet consumer needs and preferences. Case management involves, at a minimum: (1) determining the comparative costs of alternative care plan options; (2) calculating the private as well as public costs of the provider services recommended in the care plan; and (3) monitoring service expenditures over time.
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Findings from Studies of the Case Management Process

*Linkages:* A study of the Linkages Program in California, a statewide case management program offered to frail older persons and disabled adults in order to prevent premature or inappropriate institutionalization, examined whether services were being provided as intended. Results of the study indicated that “Linkages has been successful in reaching the population that it was designed to help” (p. 17), although considerable variations in client characteristics appeared across individual sites (Lee, 2001). Findings from this study also “point to the possible lack of coordination in the overall administration or delivery of health and social services” and that “identifying these gaps could help refine ongoing efforts in targeting persons with unmet needs” (Lee, 2001, p. 18).

*PASSPORT:* Ohio’s PASSPORT Program, a state-operated home care program designed to expand and coordinate in-home care for frail and disabled individuals at-risk of nursing home placement, developed and applied several process-related performance indicators to ensure compliance with case management standards. A few examples of Ohio’s PASSPORT Program’s indicators include: the case manager’s assessment of eligibility criteria; timeliness of completing case management tasks; case manager actions regarding cost criteria; and the program’s performance appraisal standards. In addition to the use of performance indicators, the PASSPORT program

employed strategies of performance appraisals and a staff best practice panel in an effort to ensure compliance to case management program standards.

An evaluation of Ohio's PASSPORT Program comparing participant characteristics with eligibility criteria found that "almost all (nearly 99 percent) of the clients reviewed did indeed meet the nursing home level of care criterion required for participation in PASSPORT" (Phillips, Applebaum, and Atchley, 1990, p. 61). Assessments were completed within five days following referral, as required, in approximately 80 percent of cases reviewed. Consumer satisfaction with Ohio's PASSPORT program was measured in two areas, service satisfaction and client respect. In general, clients reported high levels of service satisfaction: 91% felt that all or most of their service needs were met, 92% reported getting the kinds of services they desired, and 99% of clients felt that staff treated them with respect.

*California Partnership for Long Term Care: Scharlach, et al. (2000)* recently completed a study investigating the experiences of long-term care insurance policyholders in light of existing California regulations and standard practices in long-term care case management. State regulations specify that case management should take "an all-inclusive look at a person's total needs and resources." The evaluation included a review of case records, revealing that assessment instruments used to make comprehensive assessment were not adequate to the task. Deficits were identified in the areas of assessing emotional and psychological well-being, nutrition, tobacco and alcohol use, environmental safety, emergency response systems, social activity, culture and ethnicity, rehabilitation potential, and need for case management. The evaluation

found that most care plans included problem and goal statements, but lacked specificity and did not cover all problems identified in the assessment. Cost, frequency, and potential informal supports were also often omitted from the care plan.

*National Long-Term Care Channeling Demonstration:* Schneider (1988) studied care planning and care plan interventions in the context of the National Long-Term Care Channeling Demonstration. Case record review and case manager interviews were conducted to investigate the translation of assessments into care plans, specifically of assessment information into problem statements. The study “found that 20 to 30 percent of problem indicators in the assessments did not form the basis for problem statements in the development of the care plan” (Schneider, 1988, p. 17).

*Texas Star+Plus:* The Texas Health Quality Alliance (THQA) evaluated the care coordination process in Star+Plus, a Medicaid pilot project in Texas designed to integrate acute and long-term care. Evaluation examined the care coordination process as documented in the case record, as well as member satisfaction with care coordination services. Regarding documentation, the evaluation found that “the presence of plan interventions and service authorizations was positively associated with the number of need indicators in the member record” (Texas Health Quality Alliance, 2001, p. 3), and that “plan interventions and service authorizations are directly tied to member need” (THQA, 2001, p. 4). Regarding member satisfaction, the evaluation found that:

- Approximately 48% of members reported being contacted by a care coordinator during the last 6 months.
- Approximately 80% of members reported being ‘satisfied’ or ‘very satisfied’ with how the care coordinator or plan representative explained information.
- Approximately 64% of members rated Care Coordination services at their plan as ‘good’, ‘very good’, or ‘excellent’.

### Consumer satisfaction

Perhaps the best source of data regarding the quality of case management is clients themselves. Clients are extremely open to sharing what they think is working and not working in programs, and they provide a perspective based on their experiences that can be captured before the time comes to measure service outcomes.

Client satisfaction is typically measured in terms of overall satisfaction. However, broad global satisfaction surveys may not be effective in measuring client satisfaction with specific services, such as case management. Additionally, we often find that clients report being quite satisfied with almost any care they receive, largely because of low expectations of care. Consumer satisfaction reports also may be inflated because of elders' reluctance to complain or fear of reprisals if they do so, because of their dependence on or sense of obligation to their care providers. For example, more than 93% of clients who received case management as part of the National Channeling Demonstration reported being satisfied or partly satisfied with the service arrangements; however, almost 92% of those in the control group also reported being satisfied or partly satisfied.

Applebaum and colleagues have demonstrated that more valid measures of consumer satisfaction can be obtained by asking about specific service characteristics - such as timeliness, reliability, and the adequacy of specific services -- rather than just seeking global satisfaction ratings. Moreover, for most elderly consumers, quality is most closely related to a sense of autonomy and personal control, whatever the specifics of the service under consideration (Woodruff & Applebaum, 1996). In addition to control, consumer preferences may include having a case manager who provides

information and/or is 'someone who cares', as evidenced in the Arkansas Survey Results of the Cash and Counseling Demonstration.

There have been a number of recent attempts to conceptualize specific components of consumer satisfaction, as it applies to long-term care case management. Scott Geron, for example, has developed a set of Home Care Satisfaction Measures, one of which explicitly addresses consumer satisfaction with case management services (Geron, 1997). The case management satisfaction instrument includes 13 items, addressing four dimensions: competency, service choice, and positive and negative interpersonal characteristics. Preliminary analyses suggest that scores on these satisfaction measures are associated with objective assessments of service adequacy.

#### Summary of Process Findings

Evaluating the quality of case management through the aspect of process provides some insight as to whether the steps that we take in providing services can result in better outcomes. While the structure of a case management program generally sets up a context in which services can be provided, the process we use to provide services may greatly influence service quality. Evaluating quality through process, i.e., comparing specific indicators to predetermined standards, is a systematic way to determine whether our actions are consistent with our intentions.

We need to recognize that care management quality may look quite different for different constituencies. As illustrated in Table 3, Rhode Island's AoA-funded quality improvement effort found that consumers, home care workers, and managers differed substantially in terms of how they defined quality (Project COPE, 1996). For

consumers, quality involved being treated with respect, being involved in decisions, and having as much choice as possible. For workers, quality involved having adequate training, health benefits, a fair wage, and managers who understood their needs. Managers defined quality as having reliable, trustworthy, staff that show up on time; having adequate funding; and making a difference in the lives of clients.

**Table 3. What is Quality? According to Whom?**

<b>Consumers</b>	<b>Home Care Workers</b>	<b>Managers</b>
Respect	Adequate Training	Reliable, Trustworthy Staff
Involvement in Decision-Making	Health Benefits	Adequate Funding
Maximum Choice	Fair Wage	Making a Difference in Clients' Lives

Effective quality assurance should focus on maximizing quality with a minimum of standards and compliance procedures. Standards should be sufficient for assuring at least a minimal acceptable level of care, while not stifling innovation and creativity at the top end. Data collection and reporting requirements should not be so burdensome that they interfere with good quality service provision. Moreover, it is important to note that quality control does not necessarily imply quality improvement. Just because we have some mechanism for assessing quality does not mean that we necessarily are improving our ability to achieve it.

A limitation of process-oriented approaches to quality assurance is the assumption that adherence to specific practice standards inevitably will result in better outcomes, despite the lack of empirical evidence to support these beliefs. As Kane has noted, long-term care problems are complex, multi-faceted, and multi-determined, making it exceedingly difficult to specify exactly what type and amount of intervention

best fits which situation (Kane, 1995). Moreover, reliance on untested practice standards can result in institutionalization of inappropriate or even deleterious models of care, which can stifle innovation and creativity, dooming case management agencies and their care managers to repeat endlessly the same mistakes. The classic example, of course, is nursing homes, where increased reliance on acute care standards has resulted in highly medicalized settings, even though many long-term residents may do considerably better in more flexible, caring, less regimented environments. Indeed, as research by Margaret Baltes and others has shown, the kinds of care that are considered “high quality” in nursing homes are exactly the kinds of care which contribute to excess dependency in disabled individuals.

### *Outcomes*

Ultimately, the best test of quality in case management is whether it results in its intended outcomes. Among the outcome domains that typically have been considered are the following:

1. Cost, including Cost Effectiveness and Cost Containment
2. Service Utilization, including Acute Care Hospitalization, Nursing Home Utilization, and Home and Community-Based Services
3. Functional Capacity, including Physical, Mental, and Social Functioning
4. Family Functioning, including the Amount and Type of Informal Care, as well as Types and Levels of Caregiver Strain
5. Quality of Life, including Autonomy, Psychological Well-Being, and Satisfaction

There are a number of things we might note about this list. First of all, the particular outcomes we choose to examine as indicators of the quality of long-term care

case management are a direct reflection of what we consider to be important. It is interesting, from this perspective, that the vast majority of case management effectiveness studies that have been conducted for the past 20 years focus almost exclusively on cost and utilization: (1) whether or not case management saves money; and (2) whether or not case management reduces hospitalization and nursing home placement (which is in part a proxy for cost of care). These outcomes related primarily to administrative and service-delivery goals, and only secondarily to client-level goals.

In those instances where attention has been given to outcomes more closely related to client functioning and well being, the focus has been primarily on what have been called “compensatory” outcomes, such as meeting ADL needs and assuring safety. Comparatively little attention has been given to potential constructive, or “therapeutic,” outcomes, such as improving physical or psychosocial functioning, reducing incontinence, improving quality of life, etc. To some extent, this reflects a “therapeutic nihilism” which seems to assume that there is little we can do to improve the quality of life for individuals with chronic disabilities. Some case managers have challenged these assumptions. John Danner, at Ranchos Los Amigos, for example, describes his goals as a case manager in terms of being “in the business of creating futures.”

It also is important to note that achieving certain goals can sometimes require sacrifices with regard to other goals. For example, reducing nursing home placements and decreasing costs for long-term care systems may result in increased personal and financial demands on families and other informal support structures. Similarly, efforts to

substantially improve quality of life can have fiscal implications for service delivery systems, communities, and society at large.

#### Findings from Outcome Studies

*HCFA waivers:* Between 1970 and 1985 a number of publicly financed demonstration projects were initiated to study the impact(s) of Medicaid waiver programs. According to Quinn (1993), “the fundamental hypothesis tested by these projects was whether community care could be a cost effective substitute for institutional care” (p. 23). By 1986, HCFA approved 104 waivers from 41 states to conduct demonstrations to offer case management as a Medicaid-reimbursable service in 85% of the states with case management programs (Applebaum & Austin, 1990). The primary goal of each demonstration was to reduce Medicaid costs by substituting community care for nursing home care where appropriate.

The long-term care project demonstrations employed three primary strategies for reform:

1. Developing, coordinating, and upgrading the long-term care delivery system (Triage, Georgia Alternative Health Services, New York's Nursing Home without Walls, and others);
2. Controlling client access to and utilization of institutional services (ACCESS, South Carolina Long-Term Care Project);
3. Consolidating long-term care services delivery into a single agency (On Lok, S/HMOs).

The various demonstrations experimented with different case management models. The model most commonly used in the demonstrations was the service management model, although some used the managed care model or the broker model. Most demonstrations utilized individual case managers, although four utilized multi-disciplinary teams (Kemper, et al, 1987). Intensity of case management varied;

however, a set of core case management functions was performed in all demonstrations. In most sites, case managers had the authority to offer expanded services in addition to already existing programs offered prior to demonstration funding.

Data from the demonstrations provided mixed results with regard to program effectiveness. Most demonstration sites did not identify significant reductions in the rate of nursing home placement nor produce significant reduction in overall costs. One exception was the South Carolina Community Long-Term Care (CLTC) Project, which produced a 31% reduction in nursing home days for the treatment group (Kemper (1987). A unique feature of the South Carolina CLTC demonstration was the use of a nursing home preadmission screen, used to target clients who were the most disabled and at-risk of nursing home placement. It appears that this demonstration identified and served its intended target population, thereby reducing nursing home use for one specific target group. The South Carolina CLTC Project is a good example of how expanded community services, in combination with preadmission nursing home screening, can reduce overall nursing home use.

When costs were compared, the advantage of community care over nursing home care was found to decrease as the need for services increased. As Doty (2000) reports, research projects such as the HCFA waiver demonstrations “found that expanding access to these services did not succeed in reducing—and indeed most often increased—aggregate long-term care expenditures (that is, total long-term care spending, including spending for nursing home and home and community-based services combined)” (p. 9).

*National Long-Term Care Channeling Demonstration: The Channeling Demonstration* was an inter-departmental long-term care initiative funded by HCFA, AoA, and ASPE (the Office of the Assistant Secretary for Planning and Evaluation), directed toward people 65 and older who were functionally impaired, unable to manage the essential activities of daily living (ADL) on their own, and lacking adequate informal support. This demonstration was designed to test the feasibility and effectiveness of an alternative community-based long-term care service delivery concept integrating health and social services, termed *channeling*. Planning began at the Federal level in 1978, contracts were signed with participating States in 1980, and the demonstration projects and contracts ended in 1986.

Case management was a core feature of the Channeling Demonstration, as a mechanism responsible for helping clients gain access to and coordinate the services they needed to continue to live in the community. Each client was assigned to a case manager, who was accountable for identifying the client's service needs and acting as a client advocate in negotiating the complex array of programs and services.

Two case management models were examined: the basic model and the financial control model. In the basic case management model, case managers had a small amount of direct service purchasing power to fill service gaps. The financial control model, on the other hand, provided case managers with the authority to determine the amount, duration, and scope of service they deemed necessary, subject to a number of cost controls. Allowing the case manager to design a more appropriate, efficient care plan based on need rather than funding restrictions was an attempt to control costs.

Identified goals of the Channeling Demonstration included the following: contain overall costs, increase access, match services and needs, concentrate public resources on those with the greatest need, stimulate development of home and community-based services which did not exist or were in short supply, reduce unnecessary use of publicly subsidized long-term care services, promote efficiency and quality, promote reasonable division of labor between informal support systems, privately financed services and publicly financed care, and maintain or enhance client outcomes.

Mathematica Policy Research Inc. conducted the evaluation of the National Long-Term Care Channeling Demonstration. A randomized experimental design was utilized to compare what happened under the demonstration with what would have happened in its absence. The goal of the demonstration evaluation was to identify the effect of channeling on:

- Use of formal services, particularly hospital, nursing home, and community-based
- Public and private expenditures for health services/long-term care
- Individual outcomes (mortality, physical functioning, unmet service need, social/psychological well-being)
- Caregiving (amount of care provided, amount of financial support provided, caregiver stress/satisfaction/well-being)

Key findings are displayed in Table 4 below. In general, the evaluation found increases in service utilization, client well-being, and client and caregiver life satisfaction, and reductions in unmet needs; however, nursing home utilization was not substantially reduced and there was no effect on hospital use. Cost-effectiveness was greatest at those sites where caseloads were smallest. Results indicated that, in general, the basic model was more cost-effective.

**Table 4. Comparison of Outcomes in Channeling Demonstration Models**

	<b>Basic Model</b>	<b>Financial Control Model</b>
<b>Hospital Use</b>	No Effect: At end of 12 <sup>th</sup> month, 3.6% of treatment group and 4.1% of control group were in a hospital. Differences not statistically significant.	No Effect: At end of 12 <sup>th</sup> month, 6.2% of treatment group and 5.1% of control group were in a hospital. Differences not statistically significant.
<b>Nursing Home Use</b>	No Effect: At end of 12 <sup>th</sup> month, 11.5% of treatment group and 12.6% of control group were in a nursing home. Differences not statistically significant.	No Effect: At end of 12 <sup>th</sup> month, 11.3% of treatment group and 13.5% of control group were in a nursing home. Differences not statistically significant.
<b>Receipt of Formal Community Services</b>	Substantial Increase	Substantial Increase
<b>Substitution of Formal for Informal Care</b>	No Evidence	Evidence of some substitution, however, it resulted from reductions in caregiving by some friends and neighbors rather than primary caregivers.
<b>Total Subsistence, Medical and Long-Term Care Costs</b> (Over 18-month observation)	Increase: increased costs by approximately \$19,500, or 8% above the \$18,000 in costs that would be expected without Channeling	Increase: increased costs by approximately \$26,500, or 16% over the \$23,000 that would otherwise be expected.
<b>Public Expenditures for Subsistence, Medical Treatment and Long-Term Care Services</b> (For first 18 months after enrollment)	Increase: Government costs rose by 10% (approximately \$1900/client); Reported due mostly to costs of Channeling case management and extra formal community services arranged by Channeling.	Increase: Government costs rose by 17% (approximately \$3900/client); Reported due mostly to costs of Channeling case management and extra formal community services arranged by Channeling.
<b>Reported Unmet Needs</b>	Reduced	Reduced
<b>Confidence in Receiving Needed Services</b>	Increased	Increased
<b>Satisfaction with Service Arrangements for Clients</b>	Increased	Increased
<b>Social and Psychological Well-Being</b>	Small but generally beneficial effects	Small but generally beneficial effects
<b>Longevity</b>	No Significant Effect	No Significant Effect
<b>Well-Being of Caregivers</b>	Improved by some measures, especially in terms of satisfaction with care arrangements and overall life satisfaction.	Improved by some measures, especially in terms of satisfaction with care arrangements and overall life satisfaction.

It is important to note that the comparison group in the Channeling demonstration had access to, and received, a substantial amount of case management and other services; thus, it is unclear “whether the general lack of significant treatment/control differences observed in the Channeling evaluation is due to the widespread receipt by controls of services that are comparable in effectiveness to those delivered by Channeling or due to a lack of impacts of any case management or services on institutional use is unclear” (Brown & Phillips, 1986, p. 4). This suggests that the Channeling evaluation may be “more properly thought of as a test of the effectiveness of alternative types of case management, rather than a test of case management per se” (Brown & Phillips, 1986, p. 2). The extent to which findings from the National Channeling Demonstration, specifically differences between sites, can be generalized to a broader context are unclear.

Evidence from the Channeling demonstration, as well as from previous community care evaluations, illustrates two general conclusions. One is that channeling-type programs can increase overall costs. This appears to be especially true when targeting is limited or unsuccessful, accompanied by increased use of community-based services. A second conclusion is that an increase in service utilization apparently can increase quality of life for elderly clients. An assessment of the costs and benefits of Channeling, or other community-care evaluations, must take these two conclusions into consideration. It is essentially a question of whether the benefits, which may be largely intangible, are worth the costs of producing them.

*Personal Social Services Research Unit (PSSRU) studies:* In 1993 the United Kingdom implemented the National Health Service and Community Care Act, which

mandated case management practice as a key component of efforts to improve community care. Prior to and spanning the changes in community care, several studies of case management were undertaken by the Personal Social Services Research Unit (PSSRU). These studies, cited as exemplars in U.K. policy, evaluated a model of case management that was “designed to ensure that improved performance of the core tasks of care management could contribute towards more effective and efficient long-term care for highly vulnerable people” (Challis, 1999, p. 70). The first study was conducted in Kent and provided the foundation of subsequent case management projects, such as those in Gateshead, Darlington, and Lewisham.

The Kent Community Care Project (KCCP) measured several outcomes of case management, compared with a control group who received services that were not case-managed. The KCCP case management approach utilized trained, experienced case managers who had continuous responsibility for specific cases, relatively small caseloads, and the ability to purchase a wide variety of services with a flexible budget and clear expenditure limits. Other key aspects of the approach included targeting services to older adults at risk of institutionalization, case manager knowledge of unit costs of services and the cost of each service package, systematic record keeping, and linkages with health care providers. Outcome evaluation revealed lower rates of institutionalization, higher morale, lower levels of depression, fewer unmet care needs, and lower caregiver burden and psychological distress. There was no overall increase in service cost; indeed, there were cost savings in two of six demonstration projects.

The Gateshead community care scheme built on the Kent model, and provided a way to test the portability of the model into an urban setting. One notable difference

between the Kent and Gateshead projects was that clients in Gateshead were “rather more dependent” in the areas of incontinence, immobility, and cognitive ability (Challis, 1993). Outcomes of the Gateshead project were similar to those in Kent.

Institutionalization, client depression and loneliness, and caregiver burden all decreased. Again, as with the Kent project, there was no significant increase in costs.

Improvements in well being and decreased levels of caregiver stress also were observed in a study of case management within a multidisciplinary team (Darlington Scheme), where case managers had a flexible budget as well as the responsibility of allocating the time of multipurpose care workers (Challis, 1999). Findings revealed that the gains were achieved at a lower cost than normally expended.

The Lewisham scheme developed a similar model of case management for elderly people with a diagnosis of dementia in a community-based service. Study results showed that, although costs were significantly higher in the Lewisham scheme, there was “evidence of improved well-being for the older people and more markedly so for the carers receiving the intensive care management support” (Challis, 1999, p. 71).

In each study, case managers worked with relatively small caseloads of frail elderly and were responsible for allocating funds to purchase the services needed within a fixed budget. Evaluations showed that in all settings there was a reduction in the use of institutional care facilities, the quality of life for both clients and caregivers improved significantly, and these gains were achieved at no greater cost than for individuals receiving traditional services without case management. Overall, the findings of the PSSRU studies suggest that case management can result in “an increased efficiency in the provision of social care with improved outcomes at similar or slightly lower costs”

(Challis, 1999, p. 71). It is important to note that the studies were conducted with highly vulnerable people and therefore findings cannot be generalized to case management with less vulnerable persons.

*Program of All-Inclusive Care for the Elderly (PACE)*: The Program of All-Inclusive Care for the Elderly (PACE) is an ongoing demonstration project of HCFA. In the PACE model, case management is provided through interdisciplinary teams in an integrated service delivery system. However, in a report on Factors Contributing to Care Management and Decision Making in the PACE Model, it was noted that components of case management may vary among PACE sites, including operational factors such as which team member takes on the role of client advocate, who acts as the team leader, the level of client or family caregiver participation on the interdisciplinary team, and the frequency of team meetings.

A study of the impact of PACE used a treatment/comparison group study design comparing PACE enrollees with applicants who did not enroll in the program. This impact evaluation, conducted between January 1995 and August 1997, identified the impact of PACE on health services utilization and several measures of outcomes, including health and functional status, quality of life, and satisfaction with services. The key findings of this survey, reported by Abt Associates (1998), are as follows:

- PACE enrollees had much lower rates of nursing home utilization and in-patient hospitalization than comparison group members.
- PACE enrollees had higher utilization of ambulatory services than comparison group members.
- PACE enrollees reported better health status and quality of life relative to comparison group members.
- PACE participation was associated with a lower mortality rate, holding other factors constant.
- PACE benefits appeared magnified for those with high levels of physical impairment.

According to Abt Associates (1998), “the PACE ‘effect,’ if it exists, is the product of PACE’s care management and delivery system and the fiscal discipline of capitated payment” (p. 5). According to the National PACE Association (2001), Medicare’s rate-setting methodology for PACE guarantees a minimum 5% savings. Medicare and Medicaid rate-setting methods for PACE have shown to produce savings compared to payers’ costs for comparably frail individuals in the fee-for-service health care system. In fact, a 1997 study by DataChron Health Systems found that PACE yields a 12% savings for Medicare. Additionally, Medicaid capitation payments to PACE produce an estimated 5 to 15% saving relative to Medicaid fee-for-service expenditures for a comparable population (National PACE Association, 2001).

*Arizona Long-Term Care System:* The Arizona Long-Term Care System (ALTCS) is a long-term care program for persons who are elderly, physically disabled, or developmentally disabled and who meet both financial and medical eligibility requirements. ALTCS is a program within the Arizona Health Care Cost Containment System (AHCCCS) and is funded by federal, state and county monies. Under ALTCS, a complete array of acute medical services, institutional services, behavioral health services, home and community-based services, and case management services is integrated into a single delivery package. Once enrolled in ALTCS, members have a choice of available primary care providers who coordinate care and act as gatekeepers. The case manager “coordinates care with the primary care provider and is responsible for identifying, planning, obtaining, and monitoring appropriate services that meet the member’s needs” (AHCCS Overview, 2001, p. 18).

AHCCCS has been evaluated by federal agencies, private firms, and the state legislature. A summary of the evaluation reports indicated that overall ALTCS seems to be successful in producing cost savings; indeed, the “cost of the program as compared to a traditional Medicaid program is 7% less per year for the acute care program averaged over the first 11 years of the program, and 16% less per year for the long-term care program for its first five years” (AHCCS Overview, 2001, p. 42). AHCCCS credits the success of ALTCS to the cost-effectiveness of HCBS and an effective pre-admission screening process which ensures that persons who become eligible for ALTCS are at risk of institutionalization and most likely to benefit from case management services.

**Table 5. Program Evaluation Comparisons**

PROGRAM	OUTCOMES									
	Cost	Service Utilization			Client Functional Capacity			Family Functioning	Quality of Life	
		Nursing Home Utilization	Acute Care Utilization	Home and Community-Based LTC Service Use	Physical	Mental	Social	CG Strain	Satisfaction with Services/ Needs are met	Social/Psych Well-Being
HCFA Waivers	No significant reduction	No significant reduction*	-	↑						
Channeling (Basic Model)	↑	-	-	↑	-			↓	↑	↑
Channeling (Financial Control Model)	↑ More than Basic Model	-	-	↑	- IADL, ↓ ADL -				↑	↑
PSSRU (Overall)	↓	↓		↑				↓		↑
Kent	No overall ↑, Cost savings in 2 of 6 projects	↓	↓					↓	↑	↑
Gateshead	No sig. ↑	↓		↑				↓	↑	↑
Darlington	↓	↓	↓	↑				↓	↑	
Lewisham	↑	↓			↑		↑	↓	↑	↑
PACE	↓	↓	↓		↑				↑	
ALTCS	↓	↓								

\*With the exception of South Carolina who used preadmission nursing home screening.

*Non-LTC case management effectiveness studies:* Case management is not limited to long-term care. Indeed, for more than 20 years, case management has been a central component of community-based care of persons with severe mental illness, and more recently has emerged in discussions of managed care. Much can be learned from these efforts.

A recent review of 75 studies of the effectiveness of case management in severe mental illness, for example, found that case management was associated with reductions in psychiatric symptoms, reductions in the amount of psychiatric hospitalization, more stable living arrangements, improved quality of life, and greater patient satisfaction, in at least half of the controlled studies that were examined (Mueser, Bond, Drake, & Resnick, 1998).

Long-term care case management is indeed distinguished by its intensity, breadth of services, and duration. Contrast and comparison with evaluations of other types of case management and their effectiveness must take into account these features and their impacts on case management structure, process, and outcomes.

#### Summary of Effectiveness Findings

A review of the limited existing evidence regarding the effectiveness of case management reveals relatively consistent patterns of results concerning the outcome domains mentioned earlier: cost, service utilization, functional capacity, family functioning, and quality of life. Overall cost often increases. There is often a decrease in acute care and institutionalization, accompanied by an increase in use of home and community-based services. No clear pattern can be identified with regard to outcomes related to functional capacity. Case management often impacts family functioning and

quality of life, including decreases in caregiver strain, increases in social/psychological well being and service satisfaction, and decreases in unmet need.

Several case management program characteristics appear to be associated with successful outcomes. Small caseloads, specific targeting criteria, case manager training, case manager authority (i.e., financial control and/or flexibility), and matching case management intensity to client need all seem to contribute to successful outcomes.

However, these generalizations are based on limited evidence, and must be considered preliminary. Indeed, as Summers (2000) notes, “reviews of evaluations of individual programs have not reached a consistent or generally agreed view on whether or not case management warrants the commitment made to it” (p. 86). Evidence to support claims that case management can integrate care, improve quality, reduce costs, and increase service efficiency and effectiveness is preliminary and largely inconclusive.

“Thus far, there are few well-designed comparative evaluation studies of the impact of case management that could serve as the basis for forging a consensus on preferred program structures or models for maximizing the potential of case management” (Falik, Lipson, Lewis-Idema, Ulmer, Kaplan, Robinson, Hickey, & Veiga, 1993, p. 41).

### ***Current, Ongoing Evaluations of Case Management***

#### *Cash and Counseling Demonstration*

The evaluation of the cash and counseling demonstration employs a classical experimental research design to test the effects of “cashing out” Medicaid-funded personal assistance services for the disabled. The control group receives traditional benefits where payments are made to vendors for services. Beneficiaries in the treatment group, to which they are randomly assigned, receive a monthly cash payment

in an amount roughly equal to the cash value of the services they would have received under the traditional program. It is hypothesized that cash payments will foster greater client autonomy, and therefore greater consumer satisfaction. It is also hypothesized that States will save Medicaid monies, mostly administrative expenses, from cashing out benefits. It is expected that there will be significantly different effects on consumers, caregivers, and public costs in the treatment group vs. the control group. These differences will be determined by measuring: consumers' use of, unmet need for, and satisfaction with personal assistance services; caregiver emotional stress and other demands, costs to Medicaid for personal assistance and all costs paid by Medicaid. Data will be collected through telephone surveys with program participants and caregivers and Medicare and Medicaid enrollment and claims data.

Three states are participating in the demonstration: Arkansas, New Jersey, and Florida. Arkansas was the first state to begin implementation, in December 1998. As of June 2000, over 1600 participants were enrolled. The minimum caseload target is 2000, with an optimal number of 3500. New Jersey began implementation in November 1999, and as of June 2000, approximately 700 participants were enrolled. The minimum caseload target is 2000 with an optimal number of 3500. Florida began implementation in May 2000. This is the largest state participating and it has the most complex design (the project is not being implemented for all target populations in all areas of the state and implementation in some parts of the state is being phased in over 6 month period). As of June 2000, only 4 participants were enrolled. Each state is preparing interim reports on findings from consumer surveys and final reports will be

available in 2003. A synthesis and comparison of findings from all three cash and counseling demonstrations will be conducted following the release of the final reports.

### *Minnesota Senior Health Options*

The Minnesota Department of Human Services has developed Minnesota Senior Health Options (MSHO), a program that combines Medicare and Medicaid financing and acute long-term care delivery systems. MSHO is a demonstration put into practice through federal Medicaid waivers (222, 1115) from HCFA that allow the State to combine the purchase of Medicare/Medicaid services into one contract managed by the State. This demonstration has been implemented in 7 county metro areas and will cover a five-year period. The goals of the demonstration are to 1) reorganize service delivery systems, 2) control overall cost growth, and 3) create a single point of accountability.

In an effort to conduct informal program evaluation, MSHO has conducted enrollee satisfaction surveys and focus groups. These have been valuable tools for providing feedback to the State on the impact of MSHO on plans, providers and enrollees. The Health Care Financing Administration (HCFA) has contracted with the University of Minnesota's School of Public Health's Division of Health Services Research (Dr. Robert Kane, principal investigator) to conduct a formal evaluation of MSHO. The evaluation includes case studies from interviews with health plans, providers and care coordinators. This evaluation is not yet complete.

### *Oregon*

In 1981 Oregon adopted a new state policy to develop a long-term care network to support home-based health care services for disabled elderly (and later, disabled

adults), with nursing facilities used as a last resort. The law creating Oregon's long-term care delivery system supported the concept of local control, with services coordinated by a system that was as close to the consumer as possible. Oregon is highlighted as the first state to envision and develop a long-term care system based primarily on the theory that people wanted and should be offered "the least restrictive setting" for their care.

The Oregon Senior and Disabled Services Division reported that "Oregon's success in developing community-based care and discouraging unnecessary institutionalization of seniors and people with disabilities has been built on our case management system" ([http://www.sdsd.hr.state.or.us/about/oregon\\_model.htm](http://www.sdsd.hr.state.or.us/about/oregon_model.htm), p. 6). However, no formal evaluation has been completed and outcome data are not currently available.

#### *Texas STAR+PLUS*

A current Texas grant from the Robert Wood Johnson Foundation supports the development of a data warehouse system to be used to collect, store, and report financial and program data for evaluating STAR+PLUS program outcomes. The Texas Health Quality Alliance (THQA), a collaborative of representatives from participating health plans and state departments, has already conducted an evaluation of the administrative processes and consumer satisfaction related to care coordination for members receiving long-term care services. However, analyses of cost and service utilization data are not yet available.

### *Wisconsin Family Care Program*

The Wisconsin Family Care Program is a long-term care program being piloted in nine counties. There are two major organizational components to the program: 1) Aging and Disability Resource Centers, and 2) Care Management Organizations (CMOs). The CMOs manage and deliver the long-term care benefit, which combines funding and services from a variety of existing programs into one flexible benefit. The program uses managed care principles to control long-term care costs. Goals of the program are to give people better choices about where they live and what kinds of services and supports they receive, improve access to services, improve quality through a focus on health and social outcomes, and create a cost-effective long-term care system.

The Lewin Group, an independent research group, is conducting a three-part evaluation of the program, of which the first part has been completed. The first part evaluated the implementation process of the Family Care Program (FCP), and consisted of site visits to newly developed resource centers, telephone interviews with staff, review of the program documentation, and an analysis of provider networks and provider availability, including Case Management Organizations (CMOs). The second and third parts of the evaluation will examine the impact of the FCP and conduct a cost-benefit analysis.

FCP employs both traditional and innovative methods of quality assurance. Traditional methods of QA include procedures such as monitoring compliance with contract requirements, and reviewing logs of complaints and grievances. Other QA efforts include review of individual service plans, annual quality site visits, and review of

each CMO's performance improvement plans. The QA procedures are based on a consumer-centered approach, which emphasizes outcomes relating to consumers' health and quality of life in order to achieve the ultimate purpose of "improving the quality of life for people who need the services" (DHFS, 2001, p. 46).

### ***Implications for Ensuring Quality***

The case management enterprise needs to embrace more explicitly a commitment to quality assurance. Even among exemplary case management agencies, only 39% collected any information at all that might be used to demonstrate the quality of case management services (Kane and Degenholtz, 1997). An evaluation of PASSPORT, Ohio's case-managed home care program, for example, found that internal quality assurance activities accounted for about 2% of the agency's overall budget. In addition, external quality assurance activities accounted for annual increases of 3%-5% in the cost of home care and skilled nursing services. Perhaps P.B. Crosby was wrong when he titled his book, Quality is Free; however, the real question is not how much quality assurance activities cost, but whether the costs are worth the benefits they provide.

"Now that case management has become established as a core service, the quality of service delivery will surface as a primary issue. The development of standards and quality assurance mechanisms, in a variety of service-delivery settings, will be key issues in the continuing evolution of case management services" (Austin, 1988, p. 10). Developing strategies for monitoring and evaluating the quality assurance system itself is crucial: Do efforts to promote quality actually result in better care?

Which quality assurance strategies are most effective, and under what circumstances, and at what cost?

In order to enhance the quality of case management services a combination of evaluation methods is necessary. According to Rose, “process evaluation efforts should help to pinpoint how case management services are provided and the factors that seem to affect their delivery” (1992, p. 50). Measuring program outcomes then provides information about the extent to which various program goals and objectives are met. Additionally, there is a need to determine how contextual and structural variables operate and influence case management processes and outcomes. A combination of process and outcome evaluation allows one to evaluate the outcomes of a program as well as the adequacy of the process for achieving those outcomes. Owen (as cited in Summers, 2000) emphasizes that “impact evaluation without process evaluation provides no information on how a program contributed to particular outcomes and none for improving a program” (p. 88). The results of both process and outcome evaluations can be used to assure, or improve, the quality of the case management program.

Quality assurance and evaluation are ongoing dimensions of any program and must be incorporated into the design of the ongoing case management program. General principles for designing evaluation and quality assurance systems within an agency include the following:

- Be precise about what services are being offered
- Operationalize the underlying values of the program
- Define outcomes and identify how outcomes are directly related to interventions
- Link planning, administrative, and evaluation practices together
- Assign primary responsibility within the agency

- Involve a broad range of staff participation
- Administrative staff must have a strong commitment to an integrated planning and evaluation process

### *Barriers to Evaluation and Quality Assurance*

Whatever criteria are chosen, the only real way to assess the effectiveness of case management is to compare the outcomes that accrue from the use of case management with those that would otherwise have been expected. There are various methodological and analytical impediments to conducting outcomes research.

Typically, we try to compare a treatment group, which receives case management services, with a theoretically equivalent comparison group that has not received case management. However, finding equivalent groups is not always easy. One of the problems faced in evaluating the PACE initiative, for example, is finding comparison sites that are comparable to unique communities such as On Lok.

Outcome evaluations also require that interventions be sufficiently potent and long-lasting to produce the intended effects. Yet, many projects are hampered by funding limitations and time constraints that undermine their ability to produce significantly meaningful differences. Moreover, the benefits of case management may not emerge fully until a number of months or even years after the intervention has occurred, long after data collection has ended, making it hard to trace benefits to case management. Additionally, it is often hard to separate case management outcomes from the outcomes resulting from other services, including those coordinated by case management. It should also be noted that case management is often limited by the level of availability, accessibility, acceptability, and adequacy of service options.

Also, there is some evidence that client characteristics, such as client motivation, receptivity, etc., may be at least as important as case management behavior in influencing care outcomes. Given the complexity of long-term care situations, the potency of client characteristics that typically are unmeasured and uncontrolled, and the various ways in which case management is operationalized and implemented, it is no wonder that it is so difficult to link specific outcomes to specific case management interventions.

Ideally, we would like to be able to compare case management outcomes with the outcomes that otherwise would have been expected in the absence of case management. Yet, until recently, we have had neither the will nor the technology to be able to establish expectable outcomes based on specific client characteristics. With the advent of the MDS, we may now be entering an era in which we can begin to estimate the probability associated with various client outcomes, given particular characteristics of clients and their support systems. While this may have little impact on our ability to predict outcomes for individual clients, it may contribute substantially to our ability to examine the effectiveness of case management, when aggregated across large numbers of clients with and without case management.

As stated by Geron and Chassler (1994), "case management for long-term care is a highly personalized and complex service that poses special challenges for quality measurement and assessment" (p. 71). Indeed, client outcomes are generally not evaluated because measurement is very complex, requires extensive monitoring, and is usually expensive. Additionally, the lack of specificity of multiple definitions of case management and a diversity of practice models clearly results in an "inability to

accurately compare models, programs, outcomes, and effectiveness” (Huber, 2000, p. 248). More research is needed on what effects specific models, levels, and aspects of case management have on outcomes.

## **CONCLUSION**

In order to be effective, quality assurance requires a clear definition of quality, of what one wants to assure, and what the overall goal of the case management program is. Quality assurance requires a balanced combination of evaluating structure, process, and outcomes. Additionally, there must be a willingness to use evaluation information to make needed changes in order to improve services. As Geron and Chassler (1994) stated, “case management requires a commitment to providing the highest quality case management services and to ensuring that provider services are also of the highest quality” (p. 71).

Some have argued that the increased consumerism of the coming years will naturally result in improved quality. However, this begs the question of whether consumers are indeed the best judges of quality, and what kinds of consumer education may be required to enable them to make the best choices possible. Moreover, it is not at all certain how much extra the public is willing to pay for quality case management, or to what extent consumers are willing to pay for case management at all!

However, the importance of case management research cannot be minimized. In order for the development and integration of case management programs to be successful, solid empirical information is needed:

“Research demonstrating the efficacy of particular case management models is still limited. Much more needs to be learned about the effectiveness of case

management, with particular attention to its goals, tasks, and processes and to the case manager's role and impact on the lives of older persons" (Fast & Chapin, 1996, p. 56).

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